MEDICINE.

UNDER THE CHARGE OF

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A Case of Intussusception Associated with Cancer of the Cæcum.

The following case illustrates the fact that chronic intussusception may be associated with epitheliomatous disease of the bowel; and it is highly probable that the malignant growth antedated the invagination and was the provoking cause.

A man, aged 40, was admitted to Middlesex Hospital, under the care of Dr. Coupland, complaining of a swelling in the abdomen, which had appeared after severe colicky pains lasting ten days, and attended at first by vomiting. On admission he was free from jaundice, the tongue moist and furred. On palpation there was a rounded, cylindrical swelling, dull on percussion, passing toward the right from the umbilicus, over the lower edge of the liver in the course of the colon. Under rest and low diet the tumor shifted wholly to the left of the umbilicus. Under the impression that it was a fecal tumor, enemata and mild purgatives were given for five days, with satisfactory results. At the end of this time the tumor had entirely disappeared, and the patient was discharged four days later.

About two months later he was readmitted. Acute vomiting and diarrhœa had followed the taking of some jalap four days previously; some blood was passed with the motion, and the stools had now become blackish and offensive. The abdomen was tense and tympanitic, and the face anxious. A firm, rounded, cylindrical swelling was made out crossing the abdomen from the right flank to the left hypochondrium. The pulse was fair; there were no signs of collapse, and there was no tenesmus. The nature of the case was now obvious, and from the duration of symptoms surgical interference was out of the question. Opium was given freely, and the colon gently irrigated with warm water. The next day the general condition was markedly worse; incessant vomiting, fecal at the last, and rapid failure of the pulse, ended fatally in a few hours.

The intestines were much distended and lines of red injection were observed along the contiguous coils. There was no lymph; no fecal extravasation. The hepatic flexure of the colon and the first part of the transverse colon formed a large cylindrical tumor due to the invagination into the gut of the cæcum and part of the ileum, the length of the whole mass being ten inches and a half. On laying open the colon the mucous membrane of the intussuscepted bowel was seen to be intensely reddened and swollen and it had commenced to slough near its free extremity. Here also could be seen two orifices—namely, one leading into the appendix cæci, the other into the ileum. Moreover, at the upper part of the head of the intussusception the lining membrane was replaced over an area of the size of a crown piece by a soft, whitish, fungating and ulcerating mass of new-growth. No adhesions could be made out between the serous layers of the intussusception. The rest of the intestines and the stomach showed nothing abnormal. No new-growth was found in any other part of the body.

"The case speaks for itself. It illustrates the possibility of mistaking intussusception in the adult, especially of the ileo-cæcal variety, for fecal tumor. The error has been made before, when, with a history of constipation and no urgent symptoms of obstruction, a tumor forms in the region of the colon. Fortunately, large enemata, which generally satisfactorily dispel fecal tumors, may have the same effect on the slighter forms of intussusception, with which alone the diagnostic difficulty lies; but it is remarkable that, whereas in this case enemata failed to produce that result, it took place after the administration of castor oil, a treatment which would certainly not have been adopted had the diagnosis been correctly made."—*Lancet*, 1892, No. 3592.

ACTINOMYCOSIS OF THE FOOT, COMMONLY KNOWN AS MADURA FOOT.

MR. N. I. HEWLETT, of London, gives the following description of the appearances of a specimen of "Madura foot" submitted to him for examination (*Lancet*, 1892, No. 3592):

"The disease occupies the whole of the foot and the lower third of the leg. The foot is enlarged, the bones softened and carious, and small abscess cavities are scattered through the tissues and communicate with the surface by several sinuses, the external openings of which have raised and thickened margins. There are other small cavities containing many fine yellowish particles, the so-called roe-like granules, and hence the specimen belongs to what has been described as the pale variety of Madura disease. The raised margin of a sinus was removed, and sections prepared from it. In the unstained condition the appearances are characteristic. Scattered through the sections are yellowish bodies varying somewhat in size, and frequently of a more or less reniform shape, and occurring in groups of three or four or more. These bodies are somewhat granular, have distinct margins, and are surrounded by an indistinct, radiating structure, beyond which again are round cells, the whole being enclosed in a distinct fibrous capsule. The appearances in stained specimens are conclusive as to the nature of the fungus. By the method of Gram the so-called 'fairy-rings' of the fungus are occupied by a central network of fine, branching, interlacing filaments stained blue, but the club-shaped bodies are unstained. By staining with orange-rubin, however, typical clubs can be demonstrated at the periphery."

The close resemblance of mycetoma (Madura foot) and actinomycosis hominis was first pointed out by Vandyke Carter, in 1886, and subsequently by Bristowe and Acland. Kanthack upholds their identity. No doubt the presence of a network of filaments and the apparent absence of the club-shaped bodies have been the causes of hesitation in fully recognizing the identity of the two diseases.

By using appropriate methods of staining, the microscopical appearances of the two diseases are shown to be identical. Professor Crookshank concurs in the author's opinion.

ELECTRICAL RESISTANCE OF THE URINE AS AN AID TO DIAGNOSIS.

DR. DAWSON TURNER, of Edinburgh, points out (*Lancet*, 1892, No. 3594) that the specific resistance of normal urine is on the average about 45 ohms, and that it varies, as a rule, more or less inversely with the specific gravity.

From experiments he finds that the resistance depends almost entirely on the contained salts, and that it is only when these are quite absent or very much diminished that the influence of the urea makes itself felt. Croupous pneumonia and diabetes mellitus are exceptions to the above-stated rule.

ABSENCE OF ORTHOPNŒA IN FATAL CARDIAC DILATATION, ESPECIALLY WHEN AFFECTING THE RIGHT SIDE.

DR. HANDFORD, of Nottingham, reports four fatal cases which exhibited this condition. The views of Hilton Fagge and W. Russell are considered, but in the author's opinion a satisfactory explanation is still wanting. "It would appear that the upright position gives relief chiefly in failing compensation in valvular disease and in the failing heart of renal disease; but that in dilatation, especially when the right side is affected, and in degeneration of the cardiac muscle, as in anæmia after fevers, diphtheria, septic poisoning, etc., the tendency to faintness, produced by the upright position more than counterbalances any advantages."—*Lancet*, 1892, No. 3591.

THROMBUS OF THE INFERIOR VENA CAVA FOLLOWING AN ATTACK OF ENTERIC FEVER.

At a meeting of the Glasgow Pathological and Clinical Society, **MACKINTOSH** (*Glasgow Medical Journal*, July, 1892, page 54) reported the case of a man, nineteen years old, in which, in the tenth week of the disease, the feet began to swell. Six weeks after the man got out of bed he contracted scarlet fever. The legs remained swollen. Soon after this the subcutaneous veins of the trunk and legs became prominent. The swelling of the legs gradually disappeared, but the condition of the veins persisted, though in less degree than at first. The internal mammary, the superficial epigastric, the external pudic, the internal saphenous and the superficial crcumflex iliac veins on both sides remained enlarged and tortuous, collateral circulation being established. It was thought that the condition was dependent upon the formation of a thrombus at the junction of the iliac veins and the inferior vena cava.

SCURVY.

BERTHENSON (*Deutsches Arch. f. klin. Medicin.*, xlix., H. 2-4) reports the results of a study of 225 cases of scurvy seen in the course of an epidemic at St. Petersburg in the spring and summer of 1889. Seventy-six of the number developed while under observation in hospital. The disease attacked patients in hospital in greatest number at such times as the greatest number of cases were admitted from without; not rarely, well-nourished individuals suffered, while the badly-nourished escaped. In 21 cases, scurvy developed in the course of typhoid fever. The association did not appear to depend upon the intensity of the typhoid infection. In most cases the complication appeared during convalescence.

In three cases, the symptoms of scurvy and those of typhoid fever developed simultaneously. The gravity of cases of typhoid fever was greatly increased by the coexistence of scurvy.

In only one case did typhoid fever develop as a sequel of scurvy. In the cases of tuberculosis complicated by scurvy, the development of the latter was independent of the state of the nutrition; the course of the pulmonary process was, as a rule, accelerated; the temperature was elevated, and often inverse in type; pleural and peritoneal effusions were unusually common; the sputum became putrid, and in one case pulmonary gangrene took place; hæmoptysis was not frequent; the mortality was increased. Nine cases of scurvy were complicated by pleurisy; in all, the temperature was afebrile. There were 11 cases of acute gastro-intestinal catarrh, in the course of which scurvy developed in hospital. In 20 cases, of which 11 developed in hospital, chronic intestinal catarrh was complicated with scurvy. In 38 cases, hemorrhages took place into various cavities, most commonly and exclusively into the pleuræ. Hemorrhages also took place into the retina, into bone, into the serous covering of the liver, into abscesses, and into the inflamed cornea. In 48 cases cutaneous and intermuscular extravasations of blood were observed in connection with scorbutic anemia. Scorbutic cachexia developed in 70 cases, in 17 without local symptoms; in 17, changes in the gums were observed in the absence of cachexia; in 21 cases, changes were observed in the skin, with scarcely discernible anæmia. In many cases, the general nutrition was satisfactory; in some cases it was even good. In a small proportion of cases the appetite was impaired. Nausea, epigastric pain, coated tongue, pyrosis, vomiting, meteorism, and abdominal pain were uncommon. In the majority of cases the bowels were regular; in a few they were constipated; in a larger number there was diarrhœa. Icterus was exceptional. The liver was enlarged in 7 cases, the spleen in 42. Pains in the lower extremities were present in the majority of cases, usually in the calves. In 27 cases there was headache; in others tinnitus, vertigo, delirium, a typhoid condition, hyperæsthesia, catalepsy, palpitation, insomnia, and syncope. In 85 cases the gums were soft and spongy; 17 of these presented likewise hæmophilia. Uncomplicated cases were attended with febrile reaction of intermittent type. The febrile period lasted on an average from six to eight days. The cases were divided, according to intensity, into—mild 125, moderate 48, severe 52. The disease lasted for from two weeks to seven months. In the majority of cases the course of the disease was mild. Involvement of the gums was wanting in more than half the cases. In three cases death resulted directly from the scurvy. Of the remaining 16 fatal cases, 6 were complicated by typhoid fever, 9 by tuberculosis, and 1 by pneumonia. In treatment no remedy was used as a specific. Carbolic acid was used when intestinal catarrh existed; sodium salicylate, in cases of pleural or pericardial effusions; citric acid, sulphuric acid, and phosphoric acid were also used. The diet was not exclusive, but varied. The conclusion is arrived at that scurvy is an infectious disease; it is not denied, however, that the nutrition may indirectly exert a predisposing influence.

PRECOCIOUS SYPHILITIC TABES.

PAULY, *Lyon Méd.*, 1892, No. 24, reports a case of syphilitic tabes developing four months after the initial lesion, in a man aged thirty-eight years, without neurotic heredity. It made its debut with laryngeal crisis. Fulgurant pains appeared, at first only at night. The tabetic symptoms were of rapid progress, and the general condition of the patient became quite feeble. Serious secondary lesions (iritis, mucous patches) preceded the onset of the ataxia and continued during its development.

At the time of the report, the severity of the attacks had lessened under the influence of large doses of potassium iodide and mercurial inunctions. The author, however, still looked upon the prognosis as grave.

A BACILLUS IN THE BLOOD OF TYPHUS-FEVER PATIENTS.

T. M. CHEESMAN (*N. Y. Medical Record*, 1892, No. 26, p. 716) has discovered a new bacillus in the blood of six patients suffering with typhus fever. This bacillus is pathogenetic for rabbits, guinea-pigs, and white mice, but the effect produced upon them does not resemble the symptomatology of typhus fever.

"The diameter of the bacillus varies from 0.5 μ to 0.8 μ, and the length from 1.0 μ to 2.5 μ. It occurs singly and in pairs, infrequently in short chains of six or eight. It is often club-shaped, and is found to be ovoidal in young cultures. It stains readily with the ordinary aniline dyes, and retains the color after staining by Gram's method. After some days' growth certain of the bacilli stain irregularly, presenting a sort of mottled appearance. The bacilli are immobile, and spores were not found, although some of the club-shaped bacilli show circular, unstained spots which do not color by the methods usually employed for spore-staining."

IDENTITY OF THE BACILLUS COLI COMMUNIS (ESCHERICH) AND BACILLUS TYPHI ABDOMINALIS (EBERTH).

RODET and ROUX (*Arch. de Méd. Expér.*, 1892, No. 3) publish a further contribution toward the identification of the typhoid-fever bacillus of Eberth and the bacillus coli communis.

As a result of numerous experiments, they contend that the same lesions may be produced in animals inoculated with either of these microbes; that the same variations in temperature occur, and that the evolution of the experimental disease is the same in both instances; that the results of inoculation vary under different circumstances, but that the variation is the same for the two organisms. They maintain, therefore, that the bacillus of Eberth is but a modified form of the bacillus coli communis, the modification being brought about by the pathologic processes induced in the intestine by typhoid fever.

CONDITIONS AFFECTING THE VIRULENCE OF THE BACILLUS COLI COMMUNIS.

LESAGE and **MACAIGNE** (*Arch. de Méd. Expér.*, 1892, No. 3) have investigated the pathogenetic powers of the bacillus coli communis. The organism, when derived from a normal intestine, is devoid of pathogenetic power, unless the culture be used in what they term an "excessive dose" (more than one cubic centimetre). Pathologic processes in the intestine give to the microbe an acquired virulence. Diarrhœa produced by tartar emetic had the same effect as diarrhœa from other causes; the organisms were rendered pathogenetic. Under pathologic conditions, the bacillus coli communis likewise acquires the power of penetrating the intestinal wall, and at necropsies is found disseminated to a greater or less extent throughout the cadaver. This dissemination was demonstrated in cases of diarrhœa, cholera infantum, cholera morbus, and typhoid fever. In cases of pneumonia and bronchopneumonia due to influenza, bacteria coli were found in the lungs, but the infection was not generalized. The authors consider that this invasion of the body occurs during the death agony, and is not entirely post-mortem.

Having acquired virulence, the bacillus coli communis exhibits pathogenetic powers in varying degree, and may give rise to suppuration or septicæmia, to peritoneal or visceral inflammations, which may be serious or slight.

POST-PAROXYSMAL ALBUMINURIA OF EPILEPTICS.

VOISON and **PÉRON** have made a number of observations upon post-paroxysmal albuminuria of epileptics. They state that post-paroxysmal albuminuria is found in about one-half of the cases of epilepsy, and that it is found in all varieties of the affection. The presence of albumin in certain cases may give rise to diagnostic error, the disease being confounded with eclampsia. The albuminuria of epilepsy is constant for the same patients, but it is quite fugacious, and the quantity of albumin variable. It is manifested especially in the two hours first succeeding the convulsive attack, and appears to bear a constant relation with the congestion of the face.—*Arch. de Neurologie*, 1892, vol. xxiii. p. 59.

RELATIONS BETWEEN SPONTANEOUS SOMNAMBULISM AND HYSTERIA.

MESNET (*Arch. de Neurologie*, 1892, vol. xxiii., No. 69) recalls attention to his previous communications concerning the relations between spontaneous somnambulism and hysteria (*Arch. gén. de Méd.*, February, 1860).

He reports a case which came under his observation in 1872. The patient was a young girl of seventeen years, of delicate constitution, scrofulous and anemic. For some time she had had various hysteric symptoms, such as weakness and partial anæsthesia of the extremities and hyperæsthesia along the vertebral column. For some months she was subject to nervous seizures of a peculiar kind, which gradually assumed periodicity, at first daily, afterwards twice daily, varying much in detail. The essential characters of the attack were abnormal gaiety, followed by a sudden profound slumber, lasting a varying number of hours, from which she would suddenly start up, and while apparently still asleep, indulge in violent language, attempt to leave the room, and in other ways give evidence of a somnambulistic state. This would be followed by another period of profound slumber, after which the patient would awake in a normal condition, apparently oblivious of all that had preceded. After total failure of various methods of treatment, recovery ensued upon admission to a hospital for mental diseases, through profound mental impression on assurance of recovery.

The author concludes that whatever their form—ecstatic, cataleptic, syncopal, lethargic, somnambulistic or convulsive—the nervous crises are to be considered but as the varying expressions of a morbid process identical in nature and origin, arising from a common source—hysteria.

THE MICROBE OF INFLUENZA.

PFEIFFER and BECK (*Deutsche med. Wochenschr.*, 1892, No. 21) have made further investigations into the etiology of influenza. During the course of the disease, the bacilli are best found in the morning's sputum. Care must be taken to get the bronchial secretions. The dry cover-glass preparation is quickly heated and stained for ten minutes in a 5 or 10 per cent. dilution of Ziehl's solution. Tissue sections are immersed for from ten to thirty minutes in dilute carbol-fuchsin solution, decolorized with care in absolute alcohol slightly acidulated with acetic acid, then cleared and mounted with xylol balsam.

The influenza bacilli, which are sometimes found free in the viscid mucus, sometimes enclosed in the protoplasm of the pus-cells, resemble somewhat the bacilli of mouse septicæmia, which are likewise frequently found within the leucocytes.

The organisms of influenza, however, are shorter and more slender than the others. Only an inexperienced observer could confound them with Fränkel's diplo-bacilli. They lack the so-called capsule, and cannot be stained by Gram's double stain. The number of bacilli found in sputum varies greatly.

Quite characteristic is the pathologic anatomy of the lungs in fatal cases of typical influenza pneumonia. Massive hepatization is not found, but there are many small foci of broncho-pneumonitic consolidation, usually sharply discriminated, at times confluent, and situated principally in the posterior portions.

Section through such foci of broncho-pneumonia reveals the openings of bronchial tubes, out of which can be pressed a yellowish-green purulent secretion, resembling the particles found in sputum and recognized as bronchial secretion. Microscopically these are made up of pus-cells imbedded in viscid mucus, containing free, or within the cells, typical influenza bacilli, often in great number and usually in pure culture.

It would seem from this that at least a part of the sputum of influenza comes from the finer divisions of the bronchial tree. Microscopic examination of the lung parenchyma shows that this also participates in the production of the purulent secretion of influenza.

Upon microscopic examination of the infiltrated portions of the lung, one is at once struck by the fact that the bronchi are almost completely occluded with round cells. The epithelial investment is for the most part intact, but here and there leucocytes have pushed the ciliated epithelium to one side, or penetrated beneath it.

In the pus-cells filling the lumen of the bronchi are found innumerable influenza bacilli, lying free. These microbes are also found lying free upon and between the epithelial cells. Sometimes the slender rods can be traced beneath the epithelium. In the lung-tissue itself, there are often found in the neighborhood of the bronchi (sometimes, however, altogether independent of macroscopic relation therewith) pneumonitic foci.

In the centre of these there is invariably to be seen the entire tissue, alveoli and septa, infiltrated with typical pus-cells, so that the pulmonary tissue is apparently destroyed. The surrounding lung structure presents the picture of desquamative inflammation. The large cells, which here fill the lumen of the alveoli, are less and less mixed with leucocytes, the further from the centre the point of examination. Fibrin can be demonstrated by Weigert's staining method. The pus-cells are filled with bacilli, which can be recognized as typical influenza organisms. Fränkel's diplococci were not encountered by the authors in any of these typical influenza pneumonias. They have not been able to confirm the observations of Canon concerning the presence of the bacillus in the blood of influenza patients, or those of Chantemesse concerning the pathogenetic influence of such blood upon guinea-pigs. It appears to them to be proved that the influenza process develops locally in the bronchial tree, and that a generalization of the affection by the blood can be excluded from the usual sequence of phenomena. They do not consider it proper to deny that bacilli may enter the blood, but they are inclined to doubt the influence of such entrance upon the pathogenetic evolution of influenza.

The influenza bacilli grow exclusively at body heat, and are aërobic bacteria. They have been found sensitive to desiccation. A temperature of 60° destroys the bacilli in bouillon in the course of five minutes. The addition of chloroform acts as a disinfectant within a few minutes under like conditions. It has thus far not been possible to demonstrate the existence of a permanent form of the bacillus. In none of the cases of influenza were the bacteria described not found, nor were they found in cases in which influenza could be excluded. At necropsy they were found in such numbers and in such arrangement, that their etiologic relation seemed indubitable. Of more than one hundred rabbits inoculated with the sputum of influenza patients, not one presented the sputum septicæmia of Fränkel. Only in the case of monkeys was it possible to artificially establish a disease at all comparable with influenza.

ASSOCIATION OF TABES AND HYSTERIA.

MM. PAUL BLOCQ and J. ONANOFF (*Archives de Méd. Expér.*, 1892, No. 3) report a case occurring in the service of Charcot, in which the tabetic syndrome at first simulated hysteria.

The patient was a hostler, aged thirty-five years, without neurotic, gouty, diabetic, or rheumatic heredity. His father and one brother died of nasal hemorrhage; one brother died of hemorrhage following amputation; a third brother of pulmonary tuberculosis. The patient had had scarlatina at the age of twelve years. There was no syphilitic history. For ten or twelve years he had been slightly intemperate in the use of wine. In October, 1888, he was kicked on the right side of the head by a horse, and remained unconsicous for an hour and a half after the accident. There was no other disturbance following the injury except nightmare of a professional character. No mental trouble followed, nor did there appear to be any physical sequel until about a month later, when the patient noticed that his eyes deviated outward, and that his forehead, where the wound had cicatrized, had an icy feeling. His sight gradually failed, and he had frequent attacks of cephalalgia, conjoined with extreme weakness, which obliged him to enter the hospital. After two months he was discharged much improved. Some six months later, without appreciable cause, he began to experience pain in the right shoulder. After this had persisted for three or four days, he awoke one morning with incomplete monoplegia of the right superior extremity. Examination on his reëntering the hospital showed paresis of that extremity with anæsthesia in the neighborhood of the shoulder, sharply circumscribed by a circular line. About a year later he again came under observation, presenting the following symptoms: Paresis of the right arm and hand; abolition of tactile sensibility over the upper portion of the face as far as the labial commissures; abolition of tactile sensibility over the whole extent of the right upper extremity and that part of the thorax corresponding with the insertion of the right pectoralis major; posteriorly, tactile anæsthesia over the portion corresponding to the superior half of the right trapezius; analgesia of the upper portion of the face and over the upper portion of the trapezius; conjunctival and corneal sensibility lost; muscular sense preserved; pharyngeal reflex abolished on the right; taste delayed on the left half of the tongue; smell and hearing unaffected; double external strabismus from paresis of the motor oculi nerves; the pupils slightly and equally contracted and not reacting to light; paresis of accommodation in both eyes; contraction of both visual fields; no impairment of color sense; V = O. R. ½, O. S. ⅓; no lesion of the fundus.

The patient was weak, cachectic, had night-sweats, and presented the physical signs of advanced pulmonary tuberculosis. Having declared that ordinarily he did not sleep until the night was far advanced, he was given, at 8 P.M., four grammes of chloral; at 9.30 he was found in a profound normal slumber without significant facial expression. The right eyebrow was slightly lower than the left. The eyelids were completely closed. Each eye was successively opened with little resistance and without waking the patient. The pupils were much dilated and did not react to light. The eyeballs were fixed in permanent external strabismus to the same degree as during waking hours. On awakening the patient the pupils immediately contracted to their usual size; the strabismus was not affected. The nervous symptoms were not modified in the further progress of the case, and after a few months death occurred from tuberculosis.

Necropsy, thirty hours after death. The eyes were fixed in external strabismus. On the convexity of the right cerebral hemisphere three small yellow areas of softening had given rise to three shallow cavities, situated at the anterior part of the frontal lobe and of the temporal lobe. The medullary pia mater was very much pigmented. Macroscopically, there was no notable anomaly discovered in the medulla or spinal cord: The muscles and nerves of the eye were dissected with care. The external recti were slightly more yellowish than the other muscles of the eye. The lungs exhibited the common lesions of tuberculosis.

Microscopic examination of the cord showed in the lumbar region a quite limited area of oval shape in the centre of the column of Goll, which appeared to differ from the rest of the posterior fibres by more pronounced staining and greater abundance of nuclei. In the dorsal region characteristic lesions of posterior sclerosis were demonstrated in the neighborhood of the eighth dorsal pair, not very pronounced and greater upon the right side than upon the left. In the cervical region posterior sclerosis was marked, predominating upon the right side. In the superior cervical region the lesions reached their maximum of development, but were still confined to Burdach's columns, the asymmetry of the two sides being still more readily appreciated. In the medulla sclerotic zones were again seen symmetrically occupying the cuneiform tracts (Burdach's columns), but of greater extent upon the left than upon the right side. The sensory pyramidal tracts were not affected. The bulbar, median, and superior roots of the trigeminus, as well as the extrabulbar sensory roots, were all more or less degenerated. The motor roots were intact. The nuclei of the motor oculi were completely atrophied. The optic nerves and the sixth pair were intact.

SURGERY.

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RESECTION OF THE LIVER.

KEEN (*Boston Medical and Surgical Journal*, 1892, No. 17) details the case of a patient from whom he removed a tumor of the liver. A table containing all the reported cases of resection or amputation of the liver is added. His case is that of a woman, aged thirty-one years. Two years before coming under observation, she noticed a lump on the right side of the abdomen; it remained for several weeks, when it was lost sight of. A year later it reappeared, being at that time about the size of a walnut, but steadily increasing in size. The patient was broken down in health and felt wretchedly. Pain and discomfort led her to seek medical advice.

On examination, an oval tumor about the size of the fist was seen on the right side of the abdomen, in the situation of the kidney, separated from the liver dulness by an area of distinct resonance, of three fingers' breadth. The